



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-05-7914-01
DOLLY VINSANT MEMORIAL HOSPITAL 302 KINGS HWY SUITE 112 BROWNSVILLE TX 78521	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
EMPLOYERS INSURANCE CO OF WAUSAU Box #: 01	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In support of our position, Dolly Vinsant has previously submitted a copy of the preauthorization approval issued by carrier prior to medical services being provided. At this time, Dolly Vinsant would like to once again submit, as (**Attachment I**), a copy of the letter referenced above, and the preauthorization request which was submitted to carrier."

Amount in Dispute: \$5,975.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The entire bill was denied x170-Pre-Authorization was required, but not requested for this service per TWCC Rule 134.600. (x170)." "Preauthorization was given under Authorization # AYE4V1-12 for Palladium for Surgery. (See copy of pre-authorization letter submitted by provider.)" "Per the UB92, Box #1, the facility billing is Dolly Vinsant Memorial Hospital." "The operative report lists Dolly Vinsant Hospital as the facility." "The TAX ID number listed on the UB92, TAX ID#62-1829361, is believed to be the TAX ID number of Dolly Vinsant Hospital." "Per the Texas Department of Health, Tax ID numbers are not transferable." "We have no record of authorizing Dolly Vinsant Memorial Hospital for this date of service 7/13/2004."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
7/13/2004	A, X170	Outpatient Surgery	\$5,975.00	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 2, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 17, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - A, X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
- Division rule at 28 TAC §134.600(e)(2)(F), effective March 14, 2004, 29 TexReg 2360, requires the request for preauthorization to include "the facility name and estimated date of proposed health care." The requestor submitted a copy of a preauthorization request report dated 06/29/2004 that indicates to mail the approval or denial to Palladium for Surgery, but that the location of treatment was Dolly Vinsant Memorial Hospital.

3. Division rule at 28 TAC §134.600(f)(8), effective March 14, 2004, 29 TexReg 2360, states that the carrier shall “not condition an approval or change any elements of the request as listed in subsection (e)(2), unless the condition or change is mutually agreed to by the health care provider and carrier and the agreement is documented.” The insurance carrier gave preauthorization approval on 7/7/2004 for the right lumbar sympathetic block to be performed at Palladium for Surgery. The insurance carrier changed the facility location of treatment on the preauthorization approval report. The documentation does not support that this change was mutually agreed by the parties and that the agreement was documented. Therefore, the Division finds that the insurance carrier did not support this change in facility location in accordance with Division rule at 28 TAC §134.600(f)(8).
4. Division rule at 28 TAC §134.600(h)(2), effective March 14, 2004, 29 TexReg 2360, states “The non-emergency health care requiring preauthorization includes (2) outpatient surgical or ambulatory surgical services...” Based upon the submitted documentation, the Division finds that preauthorization approval was given for the disputed services in accordance with Division rule at 28 TAC §134.600(h)(2). The respondent’s EOB denial reason codes of “A and X170” are not supported, and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
5. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
8. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor asks to be reimbursed the full amount of the billed charges.
 - The requestor does not discuss or explain how payment of \$5,975.00 would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division

concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

12/8/2010

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.